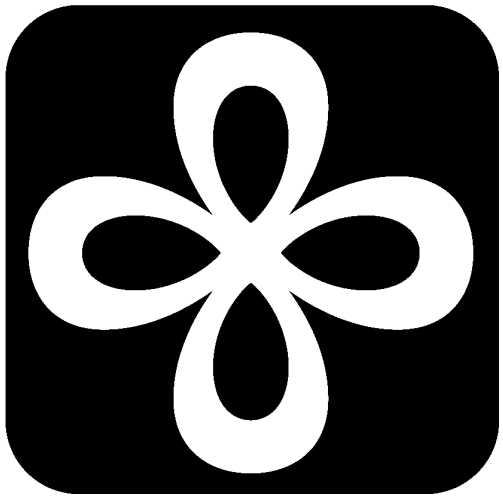
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

# MEDICAID



# Provider Manual

## Rehabilitation Agency

**CHAPTER E. COVERAGE AND LIMITATIONS** Page



**CHAPTER F. BILLING AND PAYMENT**



**APPENDIX**

# I. REHABILITATION AGENCIES ELIGIBLE TO PARTICIPATE

A rehabilitation agency is eligible to participate in Medicaid if it is certified eligible to participate as a rehabilitation agency in the Medicare program.

# II. COVERAGE OF SERVICES

Covered services are physical therapy, occupational therapy, and speech therapy. Policy regarding coverage of these services is primarily that of the Medicare program.

To be reimbursable under Medicaid, the services must meet all the following conditions:

- All services must be determined to be medically necessary and reasonable.
- All services must meet a significant need of the patient that cannot be met by a significant other, a friend, or medical staff; must meet accepted standards of medical practice.
- All services must be specific and effective treatment for a patient's medical or disabling condition.
- A licensed skilled therapist must complete a plan of treatment every 30 days and indicate the type of service required.
- The plan must contain the information noted under **II.G. Plan of Treatment**.

There is no specific limit on the number of visits that Medicaid will cover, as long as the amount of service:

- Is medically necessary in the individual case, and
- Is related to a diagnosed impairment or disabling condition, and
- Meets current standard of practice in each related field, and
- Is within the limits described later in this chapter.

You must submit documentation with each claim to support the need for the number of services provided.

Payment shall be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic therapy or trial therapy.

A unit of treatment is considered to be 15 minutes in length. Therapy sessions must meet the following criteria:

- There must be face-to-face patient contact.
- Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month may not exceed that for individual therapy.
- Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date, unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition.

  If more than a 60-minute session is required for a treatment session, submit additional documentation of the specific condition and the need for the longer treatment with the claim.
- Progress must be documented in measurable statistics on either the care plan or the progress notes for services to be reimbursed.

With the three rehabilitation therapy modes, specific conditions must be met for reimbursement to be made. Those conditions are listed under the individual therapy modes.

## A. Physical Therapy

The coverage decision for physical therapy shall be based on the need for the skills of a therapist and not only on the diagnosis.

1. To be covered under rehabilitation agency services, physical therapy services must:

   - Relate directly and specifically to an active written treatment plan.
   - Follow a treatment plan established by the licensed skilled therapist after consultation with the physician.
   - Be reasonable and necessary to the treatment of the patient's illness, injury, or disabling condition.
   - Be specific and effective treatment for the patient's medical or disabling condition.
   - Be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

2. The initial physical therapy evaluation must be provided by a licensed physical therapist.

3. A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as allowed by Iowa licensure.

4. There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time, based on the patient's restorative potential assessed by the physician. (See **II.F. Diagnostic or Trial Therapy**.)

5. It must be demonstrated that there is a need to establish a safe and effective maintenance program related to a specific illness, injury, or disabling condition.

6. The amount, frequency and duration of the services must be reasonable.

7. When a patient is under a restorative physical therapy program, the patient's condition is regularly re-evaluated and the program adjusted by the physical therapist. It is expected then, that the physical therapist has designed a maintenance program before discharge.

   Consequently, maintenance programs that are not established until after the restorative program has been completed, are not considered reasonable and necessary to the treatment of the patient's condition and are excluded from coverage. Refer to **II.D. Restorative Therapy** for further information.

8. For coverage of design and monitoring of a maintenance program, see **II.E. Maintenance Therapy**.

9. For coverage of diagnostic or trial therapy, refer to **II.F. Diagnostic or Trial Therapy**.

10. Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require skills of a qualified physical therapist. These are covered when the condition is complicated by other conditions, such as circulatory deficiency or open wounds, or if the service is an integral part of a skilled physical therapy procedure.

11. Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular, or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk.

    Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, or nursing personnel. Therefore, it is not a covered physical therapy service.

12. Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

13. Range-of-motion tests must be performed by a qualified physical therapist. Range-of-motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility. Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

    Range-of-motion to unaffected joints only does not constitute a covered physical therapy service.

14. Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy, e.g., work-hardening programs. Initial instruction for such programs is a covered service.

15. Therapeutic exercise may constitute a physical therapy service due either to the type of exercise employed or the condition of the patient.

16. Use of isokinetic or isotonic equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament, or tendon injury or postsurgical trauma. Billing can be made only for the time the therapist actually spends instructing the patient and assessing the patient's progress.

## B. Occupational Therapy

1. To be covered under rehabilitation agency services, occupational therapy services must:

   a. Be included in a plan of treatment;

   b. Improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the patient's ability to perform tasks required for independent functioning;

   c. Be prescribed by a physician under a plan of treatment;

   d. Be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist, as allowed by Iowa licensure; and

   e. Be reasonable and necessary for the treatment of the patient's illness, injury, or disabling condition.

2. Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition. However, in cases where there is a valid expectation of improvement at the time the occupational therapy program is instituted, but the expectation is not realized, services are covered only up to the time one would reasonably conclude the patient would not improve. Refer to **II.D. Restorative Therapy**. (See **II.F. Diagnostic or Trial Therapy**.)

3. For coverage of design and monitoring of a maintenance program, refer to **II.E. Maintenance Therapy**.

4. For coverage of diagnostic or trial therapy, refer to **II.F. Diagnostic or Trial Therapy**.

5. The selection and teaching of tasks designed to restore physical function are covered.

6. Planning and implementing therapeutic tasks are covered. Examples include activities to restore sensory-integrative functions, and providing motor and tactile activities to increase input and improve responses for a stroke patient.

7. The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which requires the skill of a licensed therapist and meets the definition of restorative therapy is covered. Refer to **II.D. Restorative Therapy** for further information.

8. The designing, fabricating, and fitting of orthotic self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

9. Vocation and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

## C. Speech Therapy

1. To be covered by Medicaid as rehabilitation agency services, speech therapy services must:

    a. Be included in a plan of treatment established by licensed, skilled therapist after consultation with the physician;

    b. Relate to a specific medical diagnosis or disabling condition which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, (see **II.F Diagnostic or Trial Therapy**); and,

    c. Require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

2. Speech therapy activities which are considered covered services include restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of:

    a. Voice,

    b. Fluency,

    c. Articulation,

    d. Language, or

    e. Swallowing disorders resulting form any condition other than mental impairment.

Treatment of these conditions is payable if restorative criteria are met. Refer to **II.D. Restorative Therapy**.

3. Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness, injury, or disabling condition. Group therapy is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

4. Teaching a patient to use sign language or to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions for these services to be reimbursable. (See **II.F. Diagnostic or Trial Therapy**.)

5. Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program, in accordance with the requirements of maintenance therapy, and monitoring the progress are covered. For coverage of design and monitoring of a maintenance program, see **II.E. Maintenance Therapy**.

## D. Restorative Therapy

Restorative therapy must be reasonable and necessary to the treatment of the patient's illness, injury, or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that the demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment. If at any point of an illness or

disabling condition, it is determined that this expectation will not be realized, the services are no longer considered reasonable and necessary.

Examples of covered service:

1. Physician has ordered gait evaluation and training for a patient whose gait has been materially impaired by scar tissue resulting from burns. Physical therapy services to evaluate the patient's gait, to establish a gait training program, and to provide the skilled services necessary to implement the program are covered.

2. A patient who has had a total hip replacement is ambulatory, but demonstrates weakness and is unable to climb stairs safely. Physical therapy is reasonable and necessary to teach the patient to safely climb and descend stairs.

3. A physician orders occupational therapy for a patient who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting and bathing. The occupational therapist establishes goals for the patient's rehabilitation (to be approved by the physician), and will undertake the teaching of the techniques necessary for the patient to reach the goals. Occupational therapy services are covered at a duration and intensity appropriate to the severity of the patient's impairment and the response to treatment.

4. Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand is covered.

5. Teaching a stroke patient new techniques to enable the patient to perform feeding, dressing and other activities of daily living as independently as possible is covered.

6. Construction of a device which enables a patient to hold a utensil and feed himself/herself independently is covered.

7. Construction of a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position is covered.

8. A patient with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of her condition. She is now wheelchair-bound and, for the first time, without any expectation of achieving ambulation again. The physician has ordered physical therapy to select the proper wheelchair for her long-term use and to teach safe use of the wheelchair and safe transfer techniques to the patient and the family. Physical therapy is reasonable and necessary to evaluate the patient's overall needs, to make the selection of the proper wheelchair, and to teach the patient and family safe use of the wheelchair and proper transfer techniques.

9. Stimulating and retraining a stroke patient who has lost speech or language skills to communicate orally or through augmentative means is covered.

10. Retraining communications skills of a laryngectomized person is covered.

11. Training an abnormally dysfluent child or adult to speak more fluently is covered.

12. Training new patterns of voice production for a child or adult exhibiting vocally abusive behaviors is covered.

13. Stimulating and training a language or speech delayed child's communications skills to more closely approximate age level is covered.

14. Training oral or augmentative communication skills of a mentally or physically handicapped person where a significant discrepancy occurs between the person's cognitive abilities and current level of communication function is covered.

## E. Maintenance Therapy

Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling condition whose status is stable rather than post-hospital.

Maintenance therapy is also appropriate for persons whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels. Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel or other caregiver to carry out the program are considered a covered service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of twelve months. The plan of treatment must specify the anticipated monitoring activities of any supervisor. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After twelve months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation is considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously counterindicated restorative therapy. A statement by a developmentally disabled patient's interdisciplinary team recommending a reevaluation and stating the basis for medical necessity is considered as supporting the necessity of a reevaluation and may expedite approval.

Examples of covered services:

1. A patient with Parkinsons disease who has not been under a restorative physical therapy program may require a maintenance program established by a qualified physical therapist.

2. A patient who has received gait training has reached maximum restoration potential. The physical therapist is teaching the patient and family how to safely perform the activities which are a part of the maintenance program being established. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a therapist) are covered since they are needed to establish the program.

3. A mentally retarded adult has reached a plateau in progress in a restorative speech language therapy program; potential for further progress seems minimal though a discrepancy exists between the patient's cognitive skills and communication abilities. A maintenance program may be established to ensure continued present level of functioning.

4. A stroke patient or mentally retarded adult (for example) exhibits deficits in communication function relative to the patient's cognitive abilities, but requires a therapy plan that slowly progresses in complexity and involves repetitious exercises or activities. A program may be established to help the patient advance through the levels. However, since it is of a less complex design, it does not require the constant contact with a skilled therapist and is payable as a maintenance program only.

## F. Diagnostic or Trial Therapy

Payment is made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic therapy or trial therapy.

When patients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to established goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for patients who need evaluation in multiple environments to determine their rehabilitative potential adequately. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the patient's environment.

When, during diagnostic or trial therapy, a patient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, (or lack of therapy potential), diagnostic or trial therapy ends. When, as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy is reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the patient has a previous history of rehabilitative services, trial therapy for the same type of services generally is payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue require documentation reflecting a significant change.

Further diagnostic or trial therapy for the same issue is not considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required. They will be reviewed to determine the medical necessity of the number of hours of service provided.

The following criteria additionally must be met:

a. There must be face-to-face interaction with a licensed therapist. (An aide's services are not payable.)

b. Services must be provided on an individual basis. (Group diagnostic or trial therapy is not payable.)

c. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

d. If the patient has a previous history of rehabilitative services, trial therapy for the same type of services generally is payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

e. For patients who received previous rehabilitation treatment, consideration of trial therapy generally should occur only if the patient has incorporated any regimen recommended during prior treatment into daily life to the extent of the patient's abilities. (In the case of speech therapy, this criteria does not apply if the only goal of prior rehabilitative treatment was to learn the prerequisite speech components.)

f. Documentation should include any previous attempt to resolve problems using non-therapy personnel (e.g., residential group home staff, or family members) and whether follow-up programs from previous therapy have been carried out.

g. Referrals from residential, vocational, or other rehabilitation personnel that do not meet present evaluation, restorative, or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity, and the current medical condition, including any secondary rehabilitative diagnosis, shall be submitted with the claim.

h. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

Use the following revenue codes for billing diagnostic or trial therapy:

429 Physical therapy
439 Occupational therapy
449 Speech therapy

## G. Plan of Treatment

A plan of treatment must either be:

- Established by the physician, or
- Established by a qualified therapist and signed by the physician.

You can use the Medicare plan of treatment when all the minimum information is provided in it. The minimum information to be included on treatment plans includes:

- The certification period.
- The physician's signature and date (within the certification period).
- The date the patient was last seen by the physician (if available).*
- The patient's current medical condition.
- The patient's current functional abilities, including any disabling condition.
- The patient's functional limitations.
- A diagnosis relevant to the medical necessity of treatment.
- Dates of onset of any diagnosis for which treatment is being rendered (if applicable).*
- Prior treatment (history related to current diagnosis), if applicable or known.*
- Dates of prior hospitalization (if applicable or known).*
- Dates of prior surgery (if applicable or known).*
- The date of the last episode of instability, or the date of the last episode of acute recurrence of illness or symptoms (if applicable).*
- A brief summary of the initial evaluation or baseline.
- The patient's prognosis.
- The patient's rehabilitative potential.

- The patient's progress in measurable statistic. (See **II.F. Diagnostic or Trial Therapy**.)
- The extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions. (See **II.F. Diagnostic or Trial Therapy**.)
- Quantitative, measurable short-term and long-term functional goals. (See **II.F. Diagnostic or Trial Therapy**.)
- The services to be rendered.
- The frequency of the services.
- The discipline of the person providing the service.
- Assistance devices to be used.
- The place services are rendered.
- The period of time of the session.
- The anticipated duration of the service.
- The estimated date of discharge, if applicable.

* Attempt to gather the minimum information to be included treatment plans by reviewing the nursing home records and by contacting the referring physician.

When developing plans for teaching, training, and counseling, include the following information at a minimum:

- The medical necessity of the service.
- Prior teaching, training, or counseling provided.
- Progress in response to the services.
- The identification of specific services and goals.
- To whom the services are provided (patient, family member, etc.).
- The date of the start of the services.
- The frequency of the service.
- The estimated length of time services will be needed.

## H. Location of Service

Services may be provided in the patient's home or in a nursing care facility or residential care facility by a speech pathologist, physical therapist, or occupational therapist employed by or contracted by the agency.

Services provided a patient residing in a nursing facility or residential care facility are payable when you submit a statement signed by the facility representative verifying that the facility does not have these services available. The statement need only be submitted with the claim at the start of care, unless the situation changes.

Payment will not be made to a rehabilitation agency for therapy provided to a patient residing in an intermediate care facility for the mentally retarded, since these facilities are responsible for providing or paying for such services required by patients. Payment will not be made for service provided in a hospital.

# III. BASIS OF PAYMENT FOR SERVICES

Payment for services is based on Medicare reimbursement principles. Submit claims for payment using the applicable Current Procedural Terminology (CPT) codes.

# I. INSTRUCTIONS AND CLAIM FORM

## A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the UB-92 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

*For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.*

| FIELD NUMBER | FIELD NAME/ DESCRIPTION | INSTRUCTIONS |
|---|---|---|
| 1. | PROVIDER'S NAME, ADDRESS & TELEPHONE NUMBER | **OPTIONAL** – Enter the complete name, address, and phone number of the billing facility or service supplier. |
| 2. | PAYER CONTROL NUMBER | **LEAVE BLANK.** |
| 3. | PATIENT CONTROL NUMBER | **OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters. |

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| 4. | TYPE OF BILL | **REQUIRED*** – Enter a three-digit number consisting of one digit from each of the following categories in this sequence:<br><br>First digit Type of facility<br>Second digit Bill classification<br>Third digit Frequency<br><br><u>Type of Facility</u><br><br>1 Hospital or psychiatric medical institution for children (PMIC)<br><br>2 Skilled nursing facility<br><br>3 Home health agency<br><br>7 Rehabilitation agency<br><br>8 Hospice<br><br><u>Bill Classification</u><br><br>1 Inpatient hospital, inpatient SNF or hospice (nonhospital based)<br><br>2 Hospice (hospital based)<br><br>3 Outpatient hospital, outpatient SNF or hospice (hospital based)<br><br>4 Hospital referenced laboratory services, home health agency, rehabilitation agency<br><br><u>Frequency</u><br><br>1 Admit through discharge claim<br>2 Interim – first claim<br>3 Interim – continuing claim<br>4 Interim – last claim |
| 5. | FEDERAL TAX NUMBER | **OPTIONAL** – No entry required. |
| 6. | STATEMENT COVERS PERIOD | **REQUIRED** – Enter the month, day, and year under both the From and To categories for the period. |

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| 7. | COVERED DAYS | **REQUIRED FOR INPATIENT*** –<br><br>Inpatient, PMIC, and SNF – Enter the number of covered days. Do not use the day of discharge in your calculations.<br><br>Rehabilitation Agency – Enter the number of days the patient was seen in this billing period. The number of days is used to determine copayment liability.<br><br>Hospice Services and Home Health Agencies – Leave blank. |
| 8. | NONCOVERED DAYS | **REQUIRED FOR INPATIENT, WHERE APPLICABLE*** –<br><br>Inpatient, PMIC, and SNF – Enter the number of non-covered days, if applicable. Do not use the day of discharge in your calculations.<br><br>Hospice Services, Rehabilitation, and Home Health Agencies – Leave blank. |
| 9. | COINSURANCE DAYS | **OPTIONAL** – No entry required. |
| 10. | LIFETIME RESERVE DAYS | **OPTIONAL** – No entry required. |
| 11. | UNLABELED FIELD | **OPTIONAL** – No entry required. |
| 12. | PATIENT NAME | **REQUIRED** – Enter the last name, first name, and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification. |
| 13. | PATIENT ADDRESS | **OPTIONAL*** – Enter the full address of the recipient. |
| 14. | PATIENT BIRTHDATE | **OPTIONAL** – Enter the recipient's birthdate as month, day, and year. Completing this field may expedite processing of your claim. |
| 15. | PATIENT SEX | **REQUIRED** – Enter the patient's sex. |

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| 16. | PATIENT MARITAL STATUS | **OPTIONAL** – No entry required. |
| 17. | ADMISSION DATE | **REQUIRED*** –<br><br>Inpatient, PMIC, and SNF – Enter the date of admission for inpatient services.<br><br>Outpatient – Enter the dates of service.<br><br>Home Health Agency and Hospice – Enter the date of admission for care.<br><br>Rehabilitation Agency – No entry required. |
| 18. | ADMISSION HOUR | **REQUIRED FOR INPATIENT/PMIC/SNF** – The following chart consists of possible admission times and a corresponding code. Enter the code that corresponds to the hour patient was admitted for inpatient care. |

| Code | Time - AM | Code | Time - PM |
|---|---|---|---|
| 00 | 12:00 - 12:59 Midnight | 12 | 12:00 - 12:59 Noon |
| 01 | 1:00 - 1:59 | 13 | 1:00 - 1:59 |
| 02 | 2:00 - 2:59 | 14 | 2:00 - 2:59 |
| 03 | 3:00 - 3:59 | 15 | 3:00 - 3:59 |
| 04 | 4:00 - 4:59 | 16 | 4:00 - 4:59 |
| 05 | 5:00 - 5:59 | 17 | 5:00 - 5:59 |
| 06 | 6:00 - 6:59 | 18 | 6:00 - 6:59 |
| 07 | 7:00 - 7:59 | 19 | 7:00 - 7:59 |
| 08 | 8:00 - 8:59 | 20 | 8:00 - 8:59 |
| 09 | 9:00 - 9:59 | 21 | 9:00 - 9:59 |
| 10 | 10:00 - 10:59 | 22 | 10:00 - 10:59 |
| 11 | 11:00 - 11:59 | 23 | 11:00 - 11:59 |
| | | 99 | Hour unknown |

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| 19. | TYPE OF ADMISSION | **REQUIRED FOR INPATIENT/PMIC/SNF** – Enter the code corresponding to the priority level of this inpatient admission.<br>1 Emergency<br>2 Urgent<br>3 Elective<br>4 Newborn<br>9 Information unavailable |
| 20. | SOURCE OF ADMISSION | **REQUIRED FOR INPATIENT/PMIC/SNF** – Enter the code that corresponds to the source of this admission.<br>1 Physician referral<br>2 Clinic referral<br>3 HMO referral<br>4 Transfer from a hospital<br>5 Transfer from a skilled nursing facility<br>6 Transfer from another health care facility<br>7 Emergency room<br>8 Court/law enforcement<br>9 Information unavailable |
| 21. | DISCHARGE HOUR | **REQUIRED FOR INPATIENT/PMIC/SNF** – The following chart consists of possible discharge times and a corresponding code. Enter the code that corresponds to the hour patient was discharged from inpatient care.<br><br>See **Field 18, Admission Hour**, for instructions for accepted discharge hour codes. |

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| 22. | PATIENT STATUS | **REQUIRED FOR INPATIENT/PMIC/SNF** – Enter the code that corresponds to the status of the patient at the end of service.<br>01 Discharged to home or self care (routine discharge)<br>02 Discharged/transferred to other short-term general hospital for inpatient care<br>03 Discharged/transferred to a skilled nursing facility (SNF)<br>04 Discharged/transferred to an intermediate care facility (ICF)<br>05 Discharged/transferred to another type of institution for inpatient care or outpatient services<br>06 Discharged/transferred to home with care of organized home health services<br>07 Left care against medical advice or otherwise discontinued own care<br>08 Discharged/transferred to home with care of home IV provider<br>10 Discharged/transferred to mental health care<br>11 Discharged/transferred to Medicaid certified rehabilitation unit<br>12 Discharged/transferred to Medicaid certified substance abuse unit<br>13 Discharged/transferred to Medicaid certified psychiatric unit<br>20 Expired<br>30 Remains a patient or is expected to return for outpatient services (valid only for nonDRG claims) |
| 23. | MEDICAL/ HEALTH RECORD NUMBER | **OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters. |

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| 24. – 30. | CONDITION CODES | **CONDITIONAL*** – Enter corresponding codes to indicate whether or not treatment billed on this claim is related to any condition listed below.<br><br>Up to seven codes may be used to describe the conditions surrounding a patient's treatment.<br><br><u>General</u><br><br>01 Military service related<br>02 Condition is employment related<br>03 Patient covered by an insurance not reflected here<br>04 HMO enrollee<br>05 Lien has been filed<br><br><u>Inpatient Only</u><br><br>80 Neonatal level II or III unit<br>81 Physical rehabilitation unit<br>82 Substance abuse unit<br>83 Psychiatric unit<br>X3 IFMC approved lower level of care, ICF<br>X4 IFMC approved lower level of care, SNF<br>91 Respite care<br><br><u>Outpatient Only</u><br><br>84 Cardiac rehabilitation program<br>85 Eating disorder program<br>86 Mental health program<br>87 Substance abuse program<br>88 Pain management program<br>89 Diabetic education program<br>90 Pulmonary rehabilitation program<br>98 Pregnancy indicator – outpatient or rehabilitation agency |

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|---|---|---|
| | | Special Program Indicator<br><br>A1 EPSDT<br>A2 Physically handicapped children's program<br>A3 Special federal funding<br>A4 Family planning<br>A5 Disability<br>A6 Vaccine/Medicare 100% payment<br>A7 Induced abortion – danger to life<br>A8 Induced abortion – victim rape/incest<br>A9 Second opinion surgery<br><br>Home Health Agency (Medicare not applicable)<br><br>XA Condition stable<br>XB Not homebound<br>XC Maintenance care<br>XD No skilled service |
| 31. | UNLABELED FIELD | **OPTIONAL** – No entry required. |
| 32. – 35. A. & B. | OCCURRENCE CODES AND DATES | **REQUIRED IF APPLICABLE*** – If any of the occurrences listed below is applicable to this claim, enter the corresponding code and the month, day, and year of that occurrence.<br><br>Accident Related<br><br>01 Auto accident<br><br>02 No fault insurance involved, including auto accident/other<br><br>03 Accident/tort liability<br><br>04 Accident/employment related<br><br>05 Other accident<br><br>06 Crime victim |

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|---|---|---|
| | | Insurance Related<br>17 Date outpatient occupational plan established or reviewed<br>24 Date insurance denied<br>25 Date benefits terminated by primary payer<br>27 Date home health plan was established or last reviewed<br>A3 Medicare benefits exhausted<br><br>Other<br>11 Date of onset |
| 36.<br>A. & B. | OCCURRENCE SPAN CODES AND DATES | **OPTIONAL** – No entry required. |
| 37.<br>A. – C. | TRANSACTION CONTROL NUMBER | **LEAVE BLANK.** |
| 38. | RESPONSIBLE PARTY NAME AND ADDRESS | **OPTIONAL** – No entry required. |
| 39. – 41.<br>a. – d. | VALID CODES AND AMOUNTS | **OPTIONAL** – No entry required. |
| 42. | REVENUE CODE | **REQUIRED** – Enter the appropriate corresponding revenue code for each item or service billed. Replace the "X" with a subcategory code, where appropriate, to clarify the code. Please note that all listed revenue codes are not payable by Medicaid. If you have questions concerning payment for a specific item/service, please call Provider Relations at 1-800-338-7909 or 515-327-5120 (in Des Moines). |

**11X Room & Board – Private (medical or general)**
Routine service charges for single bed rooms.

Subcategories

0 General classifications
1 Medical/surgical/GYN
2 OB
3 Pediatric
4 Psychiatric
6 Detoxification
7 Oncology
8 Rehabilitation
9 Other

**12X Room & Board – Semi-Private Two Bed (medical or general)**
Routine service charges incurred for accommodations with two beds.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

**13X Room & Board – Semi-Private Three and Four Beds (medical or general)**
Routine service charges incurred for accommodations with three and four beds.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

**14X Private (deluxe)**
Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

**15X Room & Board – Ward (medical or general)**
Routine service charge for accommodations with five or more beds.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

**16X Other Room & Board**
Any routine service charges for accommodations that cannot be included in the more specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

**17X Nursery**
Charges for nursing care to newborn and premature infants in nurseries.

Subcategories

0 General classification
1 Newborn
2 Premature
5 Neonatal ICU
9 Other

**18X Leave of Absence**
Charges for holding a room or bed for a patient while the patient is temporarily away from the provider.

Subcategory

5 Nursing home (for hospitalization)

**20X Intensive Care**
Routine service for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Subcategories

0 General classification
1 Surgical
2 Medical
3 Pediatric
4 Psychiatric
6 Post ICU
7 Burn care
8 Trauma
9 Other intensive care

**21X Coronary Care**
Routine service charge for medical care provided to patients with coronary illnesses requiring a more intensive level of care than is rendered in the general medical care unit.

Subcategories

0 General classification
1 Myocardial infarction
2 Pulmonary care
3 Heart transplant
4 Post CCU
9 Other coronary care

**22X Special Charges**
Charges incurred during an inpatient stay or on a daily basis for certain services.

Subcategories

0 General classification
1 Admission charge
2 Technical support charge
3 U.R. service charge
4 Late discharge, medically necessary
9 Other special charges

**23X Incremental Nursing Charge Rate**

Subcategories

0 General classification
1 Nursery
2 OB
3 ICU
4 CCU
9 Other

**24X All Inclusive Ancillary**
A flat rate charge incurred on either a daily or total stay basis for ancillary services only.

Subcategories

0 General classification
9 Other inclusive ancillary

**25X Pharmacy**
Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under direction of licensed pharmacies.

Subcategories

0 General classification
1 Generic drugs
2 Nongeneric drugs
3 Take home drugs
4 Drugs incident to other diagnostic services
5 Drugs incident to radiology
6 Experimental drugs
7 Nonprescription
8 IV solutions
9 Other pharmacy

**26X IV Therapy**
Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.

Subcategories

0 General classification
1 Infusion pump
2 IV therapy/pharmacy services
3 IV therapy/drug/supply delivery
4 IV therapy/supplies
9 Other IV therapy

**27X Medical/Surgical Supplies and Devices (also see 62X, an extension of 27X)**
Charges for supply items required for patient care.

Subcategories

0 General classification
1 Nonsterile supply
2 Sterile supply
3 Take home supplies
4 Prosthetic/orthotic devices
5 Pacemaker
6 Intraocular lens
7 Oxygen – take home
8 Other implants
9 Other supplies/devices

**28X Oncology**
Charges for the treatment of tumors and related diseases.

Subcategories

0 General classification
9 Other oncology

**29X Durable Medical Equipment (other than renal)**
Charges for medical equipment that can withstand repeated use (excluding renal equipment).

Subcategories

0 General classification
1 Rental
2 Purchase of new DME
3 Purchase of used DME
4 Supplies/drugs for DME effectiveness (home health agency only)
9 Other equipment

**30X Laboratory**
Charges for the performance of diagnostic and routine clinical laboratory tests. For outpatient services, be sure to indicate the code for each lab charge in UB-92 form field number 44.

Subcategories

0 General classification
1 Chemistry
2 Immunology
3 Renal patient (home)
4 Nonroutine dialysis
5 Hematology
6 Bacteriology and microbiology
9 Other laboratory

**31X Laboratory – Pathological**

Charges for diagnostic and routine laboratory tests on tissues and cultures.

For outpatient services, indicate the CPT code for each lab charge in UB-92 form field number 44.

Subcategories

0 General classification
1 Cytology
2 Histology
4 Biopsy
9 Other

**32X Radiology – Diagnostic**

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting of radio and fluorographs.

Subcategories

0 General classification
1 Angiocardiography
2 Arthrography
3 Arteriography
4 Chest x-ray
9 Other

**33X Radiology – Therapeutic**
Charges for therapeutic radiology services and chemotherapy required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Subcategories

0 General classification
1 Chemotherapy – injected
2 Chemotherapy – oral
3 Radiation therapy
5 Chemotherapy – IV
9 Other

**34X Nuclear Medicine**
Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Subcategories

0 General classification
1 Diagnostic
2 Therapeutic
9 Other

**35X CT Scan**
Charges for computed tomographic scans of the head and other parts of the body.

Subcategories

0 General classification
1 Head scan
2 Body scan
9 Other CT scans

**36X Operating Room Services**
Charges for services provided to patients by those specifically trained nursing personnel providing assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Subcategories

0 General classification
1 Minor surgery
2 Organ transplant – other than kidney
7 Kidney transplant
9 Other operating room services

**37X Anesthesia**
Charges for anesthesia services in the hospital.

Subcategories

0 General classification
1 Anesthesia incident to radiology
2 Anesthesia incident to other diagnostic services
4 Acupuncture
9 Other anesthesia

**38X Blood**
Charges for blood must be separately identified for private payer purposes.

Subcategories

0 General classification
1 Packed red cells
2 Whole blood
3 Plasma
4 Platelets
5 Leukocytes
6 Other components
7 Other derivatives (cryoprecipitates)
9 Other blood

**39X Blood Storage and Processing**
Charges for the storage and processing of whole blood.

Subcategories

0 General classification
1 Blood administration
9 Other blood storage and processing

**40X Other Imaging Services**

Subcategories

0 General classification
1 Diagnostic mammography
2 Ultrasound
3 Screening mammography
4 Positron emission tomography
9 Other imaging services

**41X Respiratory Services**
Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure. Charges for other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Subcategories

0 General classification
1 Inhalation services
3 Hyperbaric oxygen therapy
9 Other respiratory services

**42X Physical Therapy**
Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
3 Group rate
4 Evaluation or reevaluation
9 Other occupational therapy/trial occupational therapy – rehab agency

**43X Occupational Therapy**
Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
3 Group rate
4 Evaluation or reevaluation
9 Other occupational therapy/trial occupational therapy – rehab agency

**44X Speech – Language Pathology**
Charges for services provided to those with impaired functional communication skills.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
3 Group rate
4 Evaluation or reevaluation
9 Other speech-language pathology/trial speech therapy – rehab agency

**45X Emergency Room**
Charges for emergency treatment to those ill and injured persons requiring immediate unscheduled medical or surgical care.

Subcategories

0 General classification
9 Other emergency room

**46X Pulmonary Function**
Charges for tests measuring inhaled and exhaled gases. Charges for the analysis of blood and for tests evaluating the patient's ability to exchange oxygen and other gases.

Subcategories

0 General classification
9 Other pulmonary function

**47X Audiology**
Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Subcategories

0 General classification
1 Diagnosis
2 Treatment
9 Other audiology

**48X Cardiology**
Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress tests.

Subcategories

0 General classification
1 Cardiac cath lab
2 Stress test
9 Other cardiology

**49X Ambulatory Surgical Care**
Charges for ambulatory surgery not covered by other categories.

Subcategories

0 General classification
9 Other ambulatory surgical care

**50X Outpatient Services**
Outpatient charges for services rendered to an outpatient admitted as an inpatient before midnight of the day following the date of service.

Subcategories

0 General classification
9 Other outpatient services

**51X Clinic**
Clinic (nonemergency/scheduled outpatient visit) charges for providing diagnostic, preventive curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

Subcategories

0 General classification
1 Chronic pain center
2 Dental clinic
3 Psychiatric clinic
4 OB-GYN clinic
5 Pediatric clinic
9 Other clinic

**52X Free-Standing Clinic**

Subcategories

0 General classification
1 Rural health – clinic
2 Rural health – home
3 Family practice
9 Other free-standing clinic

**53X Osteopathic Services**
Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Subcategories

0 General classification
1 Osteopathic therapy
9 Other osteopathic services

**54X Ambulance**
Charges for ambulance service, usually on an unscheduled basis to the ill and injured requiring immediate medical attention.

**Note:** Ambulance is payable on the UB-92 form **only** in conjunction with inpatient admissions. Other ambulance charges must be submitted on the ambulance claim form. Documentation of medical necessity must be provided for ambulance transport. The diagnosis/documentation must reflect that the patient was nonambulatory and the trip was to the nearest adequate facility.

Subcategories

0 General classification
1 Supplies
2 Medical transport
3 Heart mobile
4 Oxygen
5 Air ambulance
6 Neonatal ambulance services
7 Pharmacy
8 Telephone transmission EKG
9 Other ambulance

**55X Skilled Nursing (home health agency only)**
Charges for nursing services that must be provided under the direct supervision of a licensed nurse ensuring the safety of the patient and achieving the medically desired result.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
9 Other skilled nursing

**56X Medical Social Services (home health agency only)**
Charges for services such as counseling patients, interviewing and interpreting problems of social situations provided to patients on any basis.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
9 Other medical social services

**57X Home Health Aide (home health agency only)**
Charges made by a home health agency for personnel primarily responsible for the personal care of the patient.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
9 Other home health aide services

**61X MRI**
Charges for Magnetic Resonance Imaging of the brain and other body parts.

Subcategories

0 General classification
1 Brain (including brainstem)
2 Spinal cord (including spine)
9 Other MRI

**62X Medical/Surgical Supplies (extension of 27X)**
Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.

Subcategories

1 Supplies incident to radiology
2 Supplies incident to other diagnostic services

**63X Drugs Requiring Specific Identification**
Charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in UB-92 form field number 44.

Subcategories

0 General classification
1 Single source drug
2 Multiple source drug
3 Restrictive prescription
4 Erythropoietin (EPO), less than 10,000 units
5 Erythropoietin (EPO), 10,000 or more units
6 Drugs requiring detailed coding

**64X Home IV Therapy Services**
Charges for intravenous drug therapy services performed in the patient's residence. For home IV providers the HCPCS code must be entered for all equipment and all types of covered therapy.

Subcategories

0 General classification
1 Nonroutine nursing, central line
2 IV site care, central line
3 IV site/change, peripheral line
4 Nonroutine nursing, peripheral line
5 Training patient/caregiver, central line
6 Training, disabled patient, central line
7 Training, patient/caregiver, peripheral line
8 Training, disabled patient, peripheral line
9 Other IV therapy services

**65X Hospice Services (hospice only)**
Charges for hospice care services for a terminally ill patient if he or she elects these services in lieu of other services for the terminal condition.

Subcategories

1 Routine home care
2 Continuous home care (hourly)
5 Inpatient respite care
6 General inpatient care
8 Care in an ICF or SNF

**70X Cast Room**
Charges for services related to the application, maintenance, and removal of casts.

Subcategories

0 General classification
9 Other cast room

**71X Recovery Room**

Subcategories

0 General classification
9 Other recovery room

**72X Labor Room/Delivery**
Charges for labor and delivery room services provided by specially trained nursing personnel to patients. This includes prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if performed in the delivery suite.

Subcategories

0 General classification
1 Labor
2 Delivery
3 Circumcision
4 Birthing center
9 Other labor room/delivery

**73X EKG/ECG (electro-cardiogram)**
Charges for the operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for the diagnosis of heart ailments.

Subcategories

0 General classification
1 Holter monitor
2 Telemetry
9 Other EKG/ECG

**74X EEG (electro-encephalogram)**
Charges for the operation of specialized equipment measuring impulse frequencies and differences in electrical potential in various brain areas to obtain data used in diagnosing brain disorders.

Subcategories

0 General classification
9 Other EEG

**75X Gastro-Intestinal Services**
Procedure room charges for endoscopic procedures not performed in the operating room.

Subcategories

0 General classification
9 Other gastro-intestinal

**76X Treatment or Observation Room**
Charges for the use of a treatment room or for the room charge associated with outpatient observation services. HCPCS code W9220 must be used with these codes (one unit per hour) on outpatient claims.

Subcategories

0 General classification
1 Treatment room
2 Observation room
9 Other treatment/observation room

**79X Lithotripsy**
Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategories

0 General classification
9 Other lithotripsy

**80X Inpatient Renal Dialysis**
A waste removal process performed in an inpatient setting using an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Subcategories

0 General classification
1 Inpatient hemodialysis
2 Inpatient peritoneal (nonCAPD)
3 Inpatient continuous ambulatory peritoneal dialysis
4 Inpatient continuous cycling peritoneal dialysis (CCPD)
9 Other inpatient dialysis

**81X Organ Acquisition (see 89X)**
The acquisition of a kidney, liver or heart for transplant use. (All other human organs fall under category 89X.)

Subcategories

0 General classification
1 Living donor – kidney
2 Cadaver donor – kidney
3 Unknown donor – kidney
4 Other kidney acquisition
5 Cadaver donor – heart
6 Other heart acquisition
7 Donor – liver
9 Other organ acquisition

**82X Hemodialysis – Outpatient or Home**
A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Subcategories

0 General classification
1 Hemodialysis/composite or other rate
2 Home supplies
3 Home equipment
4 Maintenance/100%
5 Support services
9 Other outpatient hemodialysis

**83X Peritoneal Dialysis – Outpatient or Home**
A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategories

0 General classification
1 Peritoneal/composite or other rate
2 Home supplies
3 Home equipment
4 Maintenance/100%
5 Support services
9 Other outpatient peritoneal dialysis

**84X Continuous Ambulatory Peritoneal Dialysis (CCPD) – Outpatient or Home**
A continuous dialysis process performed in an outpatient or home setting using the patient peritoneal membrane as a dialyzer.

Subcategories

0 General classification
1 CAPD/composite or other rate
2 Home supplies
3 Home equipment
4 Maintenance/100%
5 Support services
9 Other outpatient CAPD

**85X Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home**
A continuous dialysis process performed in an outpatient or home setting using a machine to make automatic changes at night.

Subcategories

0 General classification
1 CCPD/composite or other rate
2 Home supplies
3 Home equipment
4 Maintenance/100%
5 Support services
9 Other outpatient CCPD

**88X Miscellaneous Dialysis**
Charges for dialysis services not identified elsewhere.

Subcategories

0 General classification
1 Ultrafiltration
2 Home dialysis aid visit
9 Miscellaneous dialysis other

**89X Other Donor Bank (extension of 81X)**
Charges for the acquisition, storage, and preservation of all human organs (excluding kidneys, livers, and hearts – see 81X).

Subcategories

0 General classification
1 Bone
2 Organ (other than kidney)
3 Skin
9 Other donor bank

**92X Other Diagnostic Services**

Subcategories

0 General classification
1 Peripheral vascular lab
2 Electromyelogram
3 Pap smear
4 Allergy test
5 Pregnancy test
9 Other diagnostic services

**94X Other Therapeutic Services**

Charges for other therapeutic services not otherwise categorized.

Subcategories

0 General classification
1 Recreational therapy
2 Education/training
3 Cardiac rehabilitation
4 Drug rehabilitation
5 Alcohol rehabilitation
6 Complex medical equipment – routine
7 Complex medical equipment – ancillary
9 Other therapeutic services

**99X Patient Convenience Items**

Charges for items generally considered by the third party payers to be strictly convenience items, and, therefore, are not covered.

Subcategories

0 General classification
1 Cafeteria/guest tray
2 Private linen service
3 Telephone/telegraph
4 TV/radio
5 Nonpatient room rentals
6 Late discharge charge
7 Admission kits
8 Beauty shop/barber
9 Other patient convenience items

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| 43. | REVENUE DESCRIPTION | **OPTIONAL** – Enter a description of each revenue code billed. |
| 44. | HCPCS/CPT/ RATES | **CONDITIONAL*** –<br><br>Outpatient Hospital – Enter the HCPCS/CPT code for each service billed, assigning a procedure, ancillary or medical APG.<br><br>Inpatient SNF – Enter the HCPCS code W0511 for ventilator dependent patients, otherwise leave blank.<br><br>Home Health Agencies – Enter the appropriate HCPCS code from the prior authorization when billing for EPSDT related services.<br><br>All Others – Leave blank. |
| 45. | SERVICE DATE | **OPTIONAL** – Entry in this field is optional for outpatient and no entry required for all others. |
| 46. | UNITS OF SERVICE | **REQUIRED** –<br><br>Inpatient – Enter the appropriate units of service for accommodation days.<br><br>Outpatient – Enter the appropriate units of service provided per CPT/revenue code. (Batch-bill APGs require one unit = 15 minutes of service time.)<br><br>Home Health Agencies – Enter the appropriate units for each service billed. A unit of service = a visit. Prior authorization private duty nursing/personal care – one unit = an hour. |
| 47. | TOTAL CHARGES | **REQUIRED** – Enter the total charges for each code billed. |
| 48. | NONCOVERED CHARGES | **REQUIRED** – Enter the noncovered charges for each applicable code. |
| 49. | UNLABELED FIELD | **OPTIONAL** – No entry required. |

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| 50.<br>A. – C. | PAYER IDENTIFICATION | **REQUIRED** – Enter the designation provided by the state Medicaid agency. Enter the name of each payer organization from which you might expect some payment for the bill. |
| 51. | PROVIDER NUMBER | **REQUIRED** – Enter your seven-digit Medicaid provider number. |
| 52.<br>A. – C. | RELEASE OF INFORMATION CERTIFICATION INDICATOR | **OPTIONAL** – No entry required. |
| 53.<br>A. – C. | ASSIGNMENT OF BENEFITS… | **OPTIONAL** – No entry required. |
| 54.<br>A. – C. | PRIOR PAYMENTS | **REQUIRED** – If applicable, enter the amount paid by third-party payer.<br><br>Do not enter previous Medicaid payments. |
| 55.<br>A. – C. | ESTIMATED AMOUNT DUE | **OPTIONAL** – No entry required. |
| 56. – 57. | UNLABELED FIELDS | **OPTIONAL** – No entry required. |
| 58.<br>A. – C. | INSURED'S NAME | **REQUIRED** – Enter the Medicaid recipient's last name, first name, and middle initial. Verify this information on the *Medical Assistance Eligibility Card*. |
| 59.<br>A. – C. | PATIENT'S RELATIONSHIP TO INSURED | **OPTIONAL** – No entry required. |
| 60.<br>A. – C. | CERTIFICATE/ SOCIAL SECURITY NUMBER/HEALTH INSURANCE CLAIM/IDENTI-FICATION | **REQUIRED*** – Enter the patient's Medicaid identification number found on the *Medical Assistance Eligibility Card*. It should consist of seven digits followed by a letter, i.e., 1234567A. |

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| 61.<br>A. – C. | INSURED GROUP NAME | **OPTIONAL*** – No entry required. |
| 62. | INSURANCE GROUP NUMBER | **OPTIONAL*** – No entry required. |
| 63. | TREATMENT AUTHORIZATION CODE | **CONDITIONAL** – If the patient is a MediPASS patient and the service is not an emergency, the physician authorization number must be shown here. |
| 64. – 66. | EMPLOYMENT STATUS, EMPLOYER NAME AND LOCATION | **OPTIONAL*** – No entry required. |
| 67. | PRINCIPAL DIAGNOSIS CODE | **REQUIRED** – Enter the ICD-9-CM code for the principal diagnosis. |
| 68. – 75. | OTHER DIAGNOSIS CODES | **CONDITIONAL** – Enter the ICD-9-CM codes for diagnosis, other than principal, for the additional diagnosis. |
| 76. | ADMITTING DIAGNOSIS | **OPTIONAL** – No entry required. |
| 77. | "E" CODE | **OPTIONAL** – No entry required. |
| 78. | DRG ASSIGNMENT | **OPTIONAL** – No entry required. |
| 79. | PROCEDURE CODING METHOD USED | **OPTIONAL** – No entry required. |
| 80. | PRINCIPAL PROCEDURE AND DATE | **CONDITIONAL** – For the principal surgical procedure, enter the ICD-9-CM procedure code and surgery date, when applicable. |
| 81. | OTHER PROCEDURE CODES AND DATES | **CONDITIONAL** – For additional surgical procedures, enter the ICD-9-CM procedure codes and dates. |

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| 82. | ATTENDING PHYSICIAN ID | **REQUIRED** –<br><br>Inpatient Hospital, SNF, Rehab Agency, Home Health Agency, and PMIC – Enter the UPIN or seven-digit Iowa Medicaid provider number for the treating physician. The last name, first initial, and discipline are also needed. The treating physician has primary responsibility for the patient's care from the start of hospitalization.<br><br>Outpatient – Enter the UPIN or seven-digit Iowa Medicaid provider number of the physician referring the patient to the hospital. This area should not be completed if the primary physician did not give the referral. On outpatient billings, do not show treating physician information in this area.<br><br>**Note:** For lock-in patients, enter the seven-digit Iowa Medicaid provider number of the lock-in physician or clinic in place of the above. |
| 83. | OTHER PHYSICIAN ID | **OPTIONAL** – Enter the UPIN number of physician performing the principal procedure, if applicable. If a UPIN number is unavailable, enter the physician's seven-digit Iowa Medicaid provider number. The last name, first initial, and discipline are also needed. |
| 84. | REMARKS | **OPTIONAL** – No entry required. |
| 85. | PROVIDER REPRESENTATIVE SIGNATURE | **REQUIRED** – The signature of an authorized representative must be shown.<br><br>If the signature consists of computer-generated block letters, the signature must be initialed. A signature stamp may be used. |
| 86. | DATE BILL SUBMITTED | **REQUIRED** – Enter the original claim submission date. For resubmissions, be sure to indicate the original submission date, not the date of resubmission. |
| **BACK OF FORM** | **NOTE** | **REQUIRED** – The back of the claim form must be intact on every claim form submitted. |

1

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3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7 COV'D.

8 N-C'D.

9 C-I'D.

10 L-R'D.

11

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE

15 SEX

16 MS

ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC

21 D-HR

22 STAT

23 MEDICAL RECORD NO.

CONDITION CODES 24 25 26 27 28 29 30

31

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE CODE DATE

36 OCCURRENCE SPAN CODE FROM THROUGH

37 A B C

38

39 VALUE CODES CODE AMOUNT

40 VALUE CODES CODE AMOUNT

41 VALUE CODES CODE AMOUNT

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
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50 PAYER

51 PROVIDER NO.

52 REL INFO

53 ASG BEN

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56

57

DUE FROM PATIENT

58 INSURED'S NAME

59 P REL

60 CERT. - SSN - HIC. - ID NO.

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.

OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE

76 ADM. DIAG. CD.

77 E-CODE

78

79 P.C.

80 PRINCIPAL PROCEDURE CODE DATE

81 OTHER PROCEDURE CODE DATE A

OTHER PROCEDURE CODE DATE B

OTHER PROCEDURE CODE DATE C

OTHER PROCEDURE CODE DATE D

OTHER PROCEDURE CODE DATE E

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID A

OTHER PHYS. ID B

84 REMARKS

85 PROVIDER REPRESENTATIVE X

86 DATE

UB-92 HCFA-1450

OCR / Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and other information to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.
9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as a part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within the catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

### B. Facsimile of Claim Form, UB-92 (front and back)

(See the preceding pages.)

## II. REMITTANCE ADVICE AND EXPLANATION

### A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

## B. Facsimiles of Outpatient and Inpatient Remittance Advice

(See the following pages.)

ID: [redacted] (1.) R.A. NO.: 0000026 (2.) (3.) DATE PAID: 05/19/97 PROVIDER NUMBER: [redacted] (4.) PAGE: (5.) 3

| **** PATIENT NAME **** | RECIP ID | TRANS-CONTROL-NUMBER | LINE | SVC-DATE | PROC | APG | UNITS | BILLED AMT. | OTHER SOURCES | NON COV CHARGES | ALLOWED CHARGE | PAID BY MCAID | MEDICAL REC. NO. | S | EOB | EOB |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | * (6.) CLAIM TYPE: OUTPATIENT | | | | | | | * (7.) CLAIM | | PAID | | | | | |
| ORIGINAL CLAIMS: | | | | | | | | | | | | | | | | |
| (8.) [redacted] | | (9.) [redacted] 4-96339-00-550-0899-00 (11.) | | | (10.) 70220 | 351 | 1 | 81.00 | 0.00 (12.) | 0.00 (13.) | 58.60 (14.) | APG | (17.) | | 0 | 000 000 |
| MED APG: 633 (18.) | | FROM 11/18/96 TO 11/18/96 | | | MED EDUC ADD: | | | 212.45 0.00 | 0.00 | 0.00 SUBM/REIMB DIFF: | 101.04 | (15.) 0.00 0.00 | (16.) [redacted] | 0001 | 000 | 000 |
| | | | 01 | 11/18/96 | 250 | | 2 | 16.45 | 0.00 | 0.00 | 0.00 | | | | K | 000 000 |
| | | | 02 | 11/18/96 | 73510 | 351 | 1 | 81.00 | 0.00 | 0.00 | 0.00 | | | | K | 000 000 |
| | | | 03 | 11/18/96 | 99284 | 469 | 1 | 115.00 | 0.00 | 0.00 | 0.00 | | | | | 900 000 |
| [redacted] | | [redacted] 4-96340-00-55 (20.) '4-00 | | | | | | 12.00 | 0.00 | 0.00 | 0.00 | 10.96 | [redacted] | | | 900 000 |
| MED APG: | (19.) | FROM 11/20/96 TO 11/20/96 | | | MED EDUC ADD: | | | 0.00 | (21.) | SUBM/REIMB DIFF: | | 1.04 (22.) ER ADJ | | | | |
| | | | 01 | 11/20/96 | W9281 | | 1 | 12.00 | 0.00 | 0.00 | 10.96 | | | | F | 000 000 |
| [redacted] | | [redacted] 00-551-0480 | | | | | | 139.00 | 0.00 | 0.00 | 0.00 | 14.41 | [redacted] | 0001 | 000 | 000 |
| MED APG: | | FRC (24.) /30 (25.) (26.) | | | | | | 0.00 | | SUBM/REIMB DIFF: | | 124.59 (32) ER ADJ: | | | | |
| (23.) | 01 | 11/12/96 | 420 | | | | 9 | 117.00 (28.) | 0.00 (29.) | 0.00 (30.) | 0.00 (31.) | NO PAYMENT APG | (33.) | 1 | 000 | 000 |
| | 02 | 11/12/96 | Q0086 | | 054 | | 1 | 22.00 | 0.00 | 0.00 | 14.41 | BATCH APG | | Z | 000 | 000 |
| [redacted] | | [redacted] 4-96346-00-553-0487-00 | | | | | | 131.90 | 0.00 | 0.00 | 0.00 | 46.03 | [redacted] | 001X | 000 | 000 |
| MED APG: | | FROM 12/03/96 TO 12/03/96 | | | MED EDUC ADD: | | | 0.00 | | SUBM/REIMB DIFF: | | 85.87 ER ADJ: | | | | |
| | | | 01 | 12/03/96 | 80019 | | 1 | 72.40 | 0.00 | 0.00 | 15.79 | | | | F | 000 000 |
| | | | 02 | 12/03/96 | 84478 | | 1 | 20.00 | 0.00 | 0.00 | 8.17 | | | | F | 000 000 |
| | | | 03 | 12/03/96 | 84436 | | 1 | 14.60 | 0.00 | 0.00 | 9.82 | | | | F | 000 000 |
| | | | 04 | 12/03/96 | 85027 | | 1 | 18.40 | 0.00 | 0.00 | 9.25 | | | | F | 000 000 |
| | | | 05 | 12/03/96 | G0001 | | 1 | 6.50 | 0.00 | 0.00 | 3.00 | | | | F | 000 000 |

REMITTANCE T O T A L S

| | | | | |
|---|---|---|---|---|
| PAID ORIGINAL CLAIMS: (34.) | NUMBER OF CLAIMS | 1 ----- | 131.90 | 46.03 |
| PAID ADJUSTMENT CLAIMS: | NUMBER OF CLAIMS | 0 ----- | 0.00 | 0.00 |
| DENIED ORIGINAL CLAIMS: | NUMBER OF CLAIMS | 0 ----- | 0.00 | 0.00 |
| DENIED ADJUSTMENT CLAIMS: | NUMBER OF CLAIMS | 0 ----- | 0.00 | 0.00 |
| PENDED CLAIMS (IN PROCESS): | NUMBER OF CLAIMS | 0 ----- | 0.00 | 0.00 |
| AMOUNT OF CHECK: | | | | 46.03 |

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

(35.) 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 40 was intentionally left blank.

IAMC8000-R001 (CP-0-12)
AS OF 05/19/97

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 06/12/97

R E M I T T A N C E  A D V I C E

TO: [redacted] (2.) R.A. NO.: 0000026 (3.) DATE PAID: 05/19/97 PROVIDER NUMBER: [redacted] (4.) (5.) PAGE: 1

| *PATIENT NAME* LAST | FIRST | M | ID NUM | TRANS-CONTROL-NUMBER | COVERED PERIOD FROM | TO | DRG CODE | COVER DAYS | BILLED AMT. | OTHER INS. | PAID BY MCAID | NON COV CHARGES | EOB | EOB |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | * (6.) CLAIM TYPE: INPATIENT | | | | | * (7.) CLAIM STATUS: PAID | | | | | |
| ORIGINAL CLAIMS: | | | | | | | | | | | | | | |
| [redacted] | [redacted] | | [redacted] | 4-96358-00-661-0066-00 | 12/12/96 | 12/12/96 | 384 | 1 | 1095.65 | 0.00 | 673.61 | 0.00 | 900 | 000 |
| MEDICAL RECORD NUM: 395[redacted] | | | | | | | | | SUBM/REIMB DIFF: | | 422.04 | | | |
| ADJUSTMENT CLAIMS: | | | | | | | | | | | | | | |
| [redacted] | [redacted] | | [redacted] | 4-96304-00-851-1010-00 | 09/07/96 | 09/12/96 | 316 | 5- | 2053.00- | 0.00 | 4751.30- | 0.00 | | |
| MEDICAL RECORD NUM: 393[redacted] | | | | | | | | | SUBM/REIMB DIFF: | | 2698.30 | | | |
| [redacted] | [redacted] | | [redacted] | 4-96304-00-851-2010-00 | 09/07/96 | 09/12/96 | 316 | 5 | 2452.30 | 0.00 | 4751.30 | 0.00 | | |
| MEDICAL RECORD NUM: 393[redacted] | | | | | | | | | SUBM/REIMB DIFF: | | 2299.00- | | | |
| ADJ-R: 20 TCN-TO-CREDIT: 9-62696-61-000-0175-00 | | | | | | | | NET | 399.30 | 0.00 | 0.00 | | | |
| [redacted] | [redacted] | | [redacted] | 4-96338-00-253-0021-00 | 08/16/96 | 08/19/96 | | 0.00 | 736.00 | 0.00 | 0.00 | 0.00 | | |

(1.) (8.) (9.) (10.) (11.) (12.) (13.) (14.) (15.) (16.) (17.) (18.) (19.) (20.) (21.) (22.)

REMITTANCE T O T A L S (23.)

| | | | | |
|---|---|---|---|---|
| PAID ORIGINAL CLAIMS: | NUMBER OF CLAIMS | 16 | 7,669.89 | 2,674.80 |
| PAID ADJUSTMENT CLAIMS: | NUMBER OF CLAIMS | 2 | 399.30 | 0.00 |
| DENIED ORIGINAL CLAIMS: | NUMBER OF CLAIMS | 0 | 0.00 | 0.00 |
| DENIED ADJUSTMENT CLAIMS: | NUMBER OF CLAIMS | 0 | 0.00 | 0.00 |
| PENDED CLAIMS (IN PROCESS): | NUMBER OF CLAIMS | 0 | 0.00 | 0.00 |
| AMOUNT OF EFT DEPOSIT: | | | | 2,674.80 |

---- THE FOLLOWING IS A DESCRIPTION OF THE ADJUSTMENT REASONS THAT APPEAR ABOVE:

COUNT:

20 CLM ERROR (24.) 1

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

(25.) 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 42 was intentionally left blank.

## C. Outpatient Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

13. Total noncovered charges as they appear on claim.

14. Total charges allowed by Medicaid for service.

15. Total amount of Medicaid reimbursement as allowed for this claim.

16. Medical record number as assigned by provider; 10 characters are printable.

17. Explanation of benefits (EOB) code as it applies to entire claim. This code is for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for EOB code explanations.

18. Medical APG - assigned if payment is by medical APG.

19. Dates of service as reported on this claim.

20. Medical education add-on, if applicable.

21. Difference between submitted charge and reimbursement amount.

22. ER adjustment - indicates ER allowance was reduced.

23. Line item number.

24. The first date of service for the billed procedure.

25. The procedure code for the rendered service.

26. Line item procedure or ancillary APG.

27. The number of units of rendered service.

28. Charge submitted by provider for line item.

29. Amount applied to this line item from other resources, i.e., other insurance, spenddown.

30. Amount of noncovered charges for this line item.

31. Amount allowed by Medicaid for this line item.

32. Amount of Medicaid reimbursement as allowed for this line item.

33. Allowed charge source code:

    **1** Level of care per diem
    **C** Percent of charges
    **F** Fee schedule
    **K** Denied

34. Remittance totals (found at the end of the *Remittance Advice*):

    - Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
    - Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid.
    - Number of denied original claims and amount billed by provider.
    - Number of denied adjusted claims and amount billed by provider.
    - Number of pended claims (in process) and amount billed by provider.
    - Amount of check.

35. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

## D. Inpatient Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:
   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.
8. Recipient's last and first name.
9. Recipient's Medicaid (Title XIX) number.
10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.
11. Coverage dates as they appear on the claim.
12. DRG code.
13. Total number of covered days.
14. Total charges submitted by provider.
15. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
16. Total amount of Medicaid reimbursement as allowed for this claim.
17. Total noncovered charges as they appear on claim.
18. Explanation of benefits (EOB) code as it applies to entire claim. This code is for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for EOB code explanations.
19. Medical record number as assigned by provider; 10 characters are printable.

20. Difference between submitted charge and reimbursement amount.

21. Adjusted claims and reason codes. Codes are explained at the end of the *Remittance Advice*.

22. Difference in submitted charge and reimbursement amount resulting in a credit to Medicaid.

23. Remittance totals (found at the end of the *Remittance Advice*):

    - Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
    - Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid.
    - Number of denied original claims and amount billed by provider.
    - Number of denied adjusted claims and amount billed by provider.
    - Number of pended claims (in process) and amount billed by provider.
    - Amount of check.

24. Description of individual adjustment reason codes.

25. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

## III. FACSIMILE OF MEDICAID CLAIM DENIAL NOTICE, FORM 470-0385

The *Medicaid Claim Denial Notice*, form 470-0385, informs the recipient or a representative of the recipient when claims for ambulance services are denied for reasons other than problems with claim completion. A facsimile is provided for your information, since the recipient may contact you with questions concerning this notice.

(See the following pages.)

IOWA DEPARTMENT OF HUMAN SERVICES
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA 50319-0114
MEDICAID CLAIM DENIAL NOTICE

THIS IS NOT A BILL

MM/DD/YY DENIAL NOTICE NO.: YYDDD-999999

_____
_____
_____
_____

DEAR _____:

THE MEDICAID CLAIMS LISTED BELOW FOR _____, _____, WERE DENIED FOR PAYMENT UNDER THE IOWA MEDICAID PROGRAM:

PROVIDER NUMBER: _____
PROVIDER NAME : _____

TCN: YYDD-999-9999999-99
DATE OF SERVICE : MM/DD/YY
SERVICE PROVIDED : _____
AMOUNT BILLED : $99,999.99
REASON FOR DENIAL : _____
_____
_____
_____

MANUAL REFERENCE: EMPLOYEES' MANUAL, TITLE 8, APPENDIX,
_____ AGENCY, CHAPTER E, COVERAGE OF SERVICE.

SINCE THESE SERVICES WERE NOT PAYABLE BY THE MEDICAID PROGRAM, YOU MAY BE ASKED TO PAY FOR THEM.

YOUR RIGHTS OF APPEAL ARE EXPLAINED ON THE BACK OF THIS NOTICE.

SINCERELY,
IOWA MEDICAID PROGRAM

## RIGHT OF APPEAL

If you do not agree with the action taken to deny Medicaid payment for the claim submitted, you have the right to appeal. Your appeal rights and procedures for hearing are explained in the 441 Iowa Administrative Code, Chapter 7, and 481 Iowa Administrative Code, Chapter 10.

**How to Appeal.** You must appeal in writing. You may use the Department of Human Services' appeal form or you may simply send a letter asking to appeal. Attach a copy of this notice to your appeal. Send or take the appeal to the following address:

Appeals Section
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
Des Moines, Iowa 50319-0114

Your county Department of Human Services office will assist you in filing an appeal if you ask them. There is no fee or charge for an appeal. (See **Time Limits** below.)

**Time Limits.** You must appeal within 30 calendar days or before the effective date of this notice, whichever is longer, to be assured of a hearing. When the appeal is filed late (that is, more than 30 calendar days, but, less than 90 calendar days after the date of this notice) the Director of the Department of Human Services must approve whether a hearing shall be granted, based on a good cause for late filing. Any discussion between you and the Department does not extend these time periods. No hearing shall be granted if the appeal is filed more than 90 days from the date of this notice.

**Granting a Hearing.** The Department of Human Services will determine whether or not an appeal may be granted hearing. If a hearing is granted, you will be notified of the time and place. However, a hearing need not be granted if the appeal is not eligible to be heard. If no hearing is granted, you will be notified of the reason.

**Presenting Your Case.** If a hearing is granted to your appeal, you may explain your disagreement or have someone else, like a relative or friend, explain your disagreement for you. If you wish, you may be represented by an attorney, but the Department cannot pay the attorney. Your worker has information about legal services based on ability to pay that may be available to you. You may also phone Legal Services Corporation of Iowa at 1-800-532-1275. If you live in Polk County, phone Polk County Legal Aid at 243-1193.

## POLICY ON NONDISCRIMINATION

This action was taken without regard to race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief. If you have reason to believe that you may have been discriminated against due to any of the reasons stated above, you may file a complaint with the Iowa Department of Human Services (DHS) by completing a Discrimination Complaint form. Any DHS office, institution, or the Office of Equal Opportunity can give you a form. You may also file a complaint with the Iowa Civil Rights Commission (if you feel you were treated differently BECAUSE OF your race, creed, color, national origin, sex, religion or disability); or the United States Department of Health and Human Services, Office for Civil Rights.

Iowa Department of Human Services
Office of Equal Opportunity
Hoover State Office Building 5th Fl
Des Moines IA 50319-0114

US Department of Health and Human Services
Office for Civil Rights Region VII
601 E 12th St Rm 248
Kansas City MO 64106

Iowa Civil Rights Commission
Grimes State Office Bldg
211 E Maple St 2nd Fl
Des Moines IA 50309-1858

470-0385 (Rev. 5/98)

# IV. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- A paid claim amount needs to be changed, or
- Money needs to be credited back, or
- An entire remittance *advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

## A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

## B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

# PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❑ Other pertinent information for possible claim reprocessing.

**INQUIRY A**

**1. 17-DIGIT TCN**

**2. NATURE OF INQUIRY**

(Please do not write below this line)

**FISCAL RESPONSE**

**INQUIRY B**

**1. 17–DIGIT TCN**

**2. NATURE OF INQUIRY**

(Please do not write below this line)

**FISCAL AGENT RESPONSE**

| **Provider Signature/Date:** | **MAIL TO: ACS<br>P. O. BOX 14422<br>DES MOINES IA 50306-3422** | **ACS Signature/Date:** |
|---|---|---|

**Provider Please Complete:**

7-digit Medicaid Provider ID#_____

Telephone_____

Name
Street
City, St
Zip

(FOR CONSULTEC USE ONLY)

PR Inquiry Log #_____

**Received Date Stamp:**

470-3744 (Rev. 10/02)

Page 54 was intentionally left blank.

**Iowa Medicaid Program**

# CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

**SECTION A: Check the most appropriate action and complete steps for that request.**

| ❑ CLAIM ADJUSTMENT | ❑ CLAIM CREDIT | ❑ CANCELLATION OF ENTIRE REMITTANCE ADVICE |
|---|---|---|
| ♦ Attach a complete copy of claim. (If electronic, use next step.)<br>♦ Attach a copy of the Remittance Advice with corrections in **red ink**.<br>♦ Complete Sections B and C. | ♦ Attach a copy of the Remittance Advice.<br>♦ Complete Sections B and C. | ♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used.<br>♦ Attach the check and Remittance Advice.<br>♦ Skip Section B. Complete Section C. |

**SECTION B:**

| 1. 17-digit TCN | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| 2. Pay-to Provider #: | 4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A) |
|---|---|

**3. Provider Name and Address:**

**5. Reason for Adjustment or Credit Request:**

| SECTION C: | Provider/Representative Signature: |
|---|---|
| | Date: |

**FISCAL AGENT USE ONLY: REMARKS/STATUS**

**Return All Requests To:**

**ACS**
**PO Box 14422**
**Des Moines, IA 50306-3422**

For Human Services use only:

**General Letter No. 8-AP-73**
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

June 15, 1998

**REHABILITATION AGENCY MANUAL TRANSMITTAL NO. 98-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Rehabilitation Agency Manual***, Table of Contents (page 4), revised; Chapter F, *Billing and Payment*, pages 1 through 20, revised; and pages 21 through 50, new.

Chapter F is revised to update billing and payment instructions.

**Date Effective**

Upon receipt.

**Material Superseded**

Remove the following pages from the ***Rehabilitation Agency Manual***, and destroy them:

| Page | Date |
|---|---|
| Contents (pages 4 and 5) | October 1, 1992 |
| **Chapter F** | |
| 1 | October 1, 1992 |
| 2 | Undated |
| 3-10 | October 1, 1992 |
| 11 | September 1, 1987 |
| 12, 13 | October 1, 1992 |
| 14-16 | 08/01/92 |
| 17, 18 | October 1, 1992 |
| 19, 20 | Undated |

**Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

For Human Services use only:

**General Letter No. 8-AP-78**
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

July 27, 1998

**REHABILITATION AGENCY MANUAL TRANSMITTAL NO. 98-2**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Rehabilitation Agency Manual***, Chapter F, *Billing and Payment*, pages 5, 9, 10, 18, and 19, revised, and page 10a, new.

This letter transmits corrections to the billing and payment instructions as follows:

- Typographical errors are corrected on pages 5 and 18.
- Insurance-Related codes on page 9 are corrected.
- Subcategory codes which were inadvertently deleted are replaced on pages 10, 10a, and 19.

**Date Effective**

Upon receipt.

**Material Superseded**

Remove pages 5, 9, 10, 18, and 19, all dated June 1, 1998, from the ***Rehabilitation Agency Manual*** and destroy them.

**Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

**General Letter No.** 8-AP-196
Employees' Manual, Title 8
Medicaid Appendix

October 29, 2002

**REHABILITATION AGENCY MANUAL TRANSMITTAL NO. 02-1**

ISSUED BY: Iowa Department of Human Services

SUBJECT: ***REHABILITATION AGENCY MANUAL***, Table of Contents, page 4, revised;
Chapter E, *Coverage and Limitations*, pages 1, 2, 3, 4, 17, 18, and 19, revised;
Chapter F, *Billing and Payment*, pages 51 through 55, new.

Chapter E is revised to:

- Change the basis of payment for services from retrospective cost-related to the Medicare fee schedule. In accordance with Medicare, services must now be billed using appropriate Current Procedural Terminology (CPT) codes.
- Remove obsolete information about PASARR reviews and treatment plans.

Chapter F is revised to provide an inquiry process for denied claims or if claim payment was not in the amount expected. Two forms are added:

- 470-3744, *Provider Inquiry*
- 470-0040, *Credit/Adjustment Request*

Complete the *Provider Inquiry* if you wish to inquire about a denied claim or if claim payment was not as expected. Complete the *Credit/Adjustment Request* to notify the fiscal agent that:

- A paid claim amount needs to be changed; or
- Funds need to be credited back; or
- An entire *Remittance Advice* should be canceled.

**Date Effective**

October 1, 2002

**Material Superseded**

Remove the following pages from ***REHABILITATION AGENCY MANUAL*** and destroy them:

| Page | Date |
|---|---|
| Table of Contents (page 4) | June 1, 1998 |
| **Chapter E** | |
| 1-4, 17, 18 | October 1, 1992 |
| 19 (470-2740) | 4/90 |
| 20 | October 1, 1992 |

**Additional Information**

The updated provider manual containing the revised pages can be found at:

**www.dhs.state.ia.us/policyanalysis**

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.